Traditional approaches to reflective practice - history, aetiology, evidence and approaches

TRADITIONAL APPROACHES TO REFLECTIVE PRACTICE – HISTORY, AETIOLOGY, EVIDENCE AND APPROACHES

INTRODUCTION

In this chapter, we will hopefully guide you through some of the background evidence and approaches used traditionally within reflective practice in the UK. I, Jon, will start by reviewing the landscape that we are placed in to be reflective, then Katharine will illuminate the evidence base before Adam takes us on a tour of how psychoanalytic ideas are applied in reflective practice.

THE LANDSCAPE WE FIND OURSELVES IN

JON PATRICK

Across the UK's professional social care and mental health disciplines, the idea of being reflective as an integral part of a clinician's work and responsibilities has increasingly shaped the topography through which we move on a daily basis. For example, within nursing, the "Review of Mental Health Nursing" (Department of Health, 2006) and the 10 Essential Shared Capabilities for Mental Health Practice (NHS Education for Scotland, 2011) both acknowledge the importance of professionals being reflective practitioners. The recently revised Nursing and Midwifery Council Code is also hugely focused on requirements for nurses to be reflective, and providing evidence of being a reflective practitioner is now an essential requirement for future professional revalidation. The General Medical Council's "Good Medical Practice" (General Medical Council, 2013) also states that all doctors should regularly reflect on their own practice. In an influential document, '*New ways of working for applied psychologists in health and social care'*, psychologists are encouraged to lead on reflective practice provision (Department of Health, 2007).

Within this wider geography, the literature, which Katharine will helpfully describe below, reflects a growing recognition of the importance of this work in mental health settings more specifically. On acute inpatient wards there has been a particular emphasis on reflecting in groups since the policy implementation guidance for Adult Acute Inpatient Care Provision came into being. This states: '*It is essential that staff have the opportunity to jointly reflect on the impact of the day-to-day work with users and their families in order to feel informed and empowered to make the most effective interventions*.' (Department of Health, 2002, p33) This guidance draws a clear link between staff being able to jointly reflect and being able to deliver the most effective interventions. This idea has been further promoted in the Ten Essential Shared Capabilities Framework (Hope, 2004), which identified an ongoing commitment to personal and professional development through supervision and reflective practice as a necessary part of workforce development.

Sadly, as forensic practitioners will be all too aware, things do not always go smoothly or well in forensic environments. Bad things can and do happen when containing some of the most complex and disturbed people in society. A number of enquiries into the care and treatment of patients who have offended or are contained within forensic settings have all either alluded to the importance of staff engaging in a reflective process or have recommended it directly. These include the Fallon Inquiry into the Personality Disorder (PD) unit at Ashworth Hospital (Fallon, 1999), which deals with how staff and patients became caught in a pernicious, toxic and dangerous dynamic that led to serious breaches of

security. Similarly, “Falling Shadow: One Patient’s Mental Healthcare 1978–1993” (Blom-Cooper, 1995) and “Too Close to See” (Mental Welfare Commission, 2009) both illustrate how staff teams that are not being asked to formally reflect on both their relationships with and treatment of patients can lead to catastrophic, fatal consequences.

As well as these more troubling episodes, there have been a number of positive developments within forensic mental health in the UK that have provided the backdrop and impetus for development of reflective practice in Forensic Services. Locally and more latterly in Scotland, the Scottish Group of Forensic Clinical Psychologists’ Position Paper on “Psychological Approaches to Personality Disorder in Forensic Mental Health Settings” (Russell, 2016), outlined the need for a comprehensive, considered and reflective approach to the care and treatment of PD – something which reflective practice could be considered integral to.

Hovering above our Scottish relational geography, there have been a number of UK documents that have outlined the need for staff to have access to reflective practice. These include the Royal College of Psychiatrists “College Centre for Quality Improvement – Standards for Psychotherapy in Medium Secure Units” (Macallister & Jacobs, 2012). This helpfully synthesises some of the evidence with regards to the importance of provision of reflective practice in forensic settings. A second document that stresses the importance of relational security aided by having staff team’s come together and engage in reflective practice is the Royal College of Psychiatrists and Department of Health’s “See, Think, Act – Your Guide to Relational Security” (Royal College of Psychiatrists, 2015). Similarly, this is also recognised in the Royal College of Psychiatrist’s “Standards for Low Secure Services” (Tucker et al, 2012).

Reflection itself is regarded as a good thing in forensic mental health settings: from a hypothetical standpoint; from anecdotal staff report; as well as what is available in the literature (Craissati et al, 2015; Macallister and Jacobs, 2012). We will outline more about the latter in the middle of this chapter and then Adam will write about the process of reflective practice itself from a more traditional psychodynamic viewpoint after I outline some of what we feel this kind of process can help with. For our purposes, we are looking primarily at reflective practice groups (RPGs) as the key vehicle for helping staff to make sense of their experiences in forensic mental health settings. The group provides a unique opportunity to allow different perspectives to be heard and to allow alternative facets about patients, staff and the patient-staff system to be made sense of.

The aim of RPGs is therefore to encourage staff to discuss and consider the relationships that patients are having between each other, which may be causing conflict in the environment, as well as relationships between patients and staff, which may be causing conflict on the ward or within the staff team. Additionally, RPGs should consider the relationships between staff, where there may be conflict between staff members about how particular patients or patient groups are managed. In addition, staff are encouraged to consider how patients relate to themselves, ie how do they tolerate distress, their levels of self-esteem and self-efficacy, and how they manage moods. Staff are also encouraged to think about how they manage or cope themselves in relation to their work. Alongside this, RPGs should be able to facilitate reflection about the organization and how it is functioning as a whole as well as its relation to staff, teams and patients.

This may seem like a lot, but it encapsulates the wide range of interpersonal and intrapersonal dynamics that staff are having to manage when they come to work. Importantly, they may not be consciously aware that this is something they are doing. Rather than other aspects of staff supervision and management which focus on task-related activities that are pertinent to the fulfillment of job roles, ie the activities often laid out in job descriptions, RPGs are a space to think about the fundamental role of managing relationships with others that is necessary to the fulfillment of many of these tasks, but that is often not clearly stated or recognised as being required. Schön (1983) noted

that the knowledge implicit in some of the actions taken is hard to describe as it has been developed intuitively and internalised.

The explicit purpose and hope therefore when working with RPGs is to allow a space where staff can notice how they are affected by patients and process communications from patients rather than 'act out' with them. Hopefully, this will allow staff to minimize splitting and reduce the negative emotional impact of forensic work, in turn creating more resilient and caring teams. Such teams are more able to make sense of patient communications and notice risky situations developing and work to minimize and obviate these.

Together with this explicit task there is an implicit set of outcomes for RPGs also; these are to reduce staff sickness and burnout, improve morale and, importantly, to work on increasing the team's empathy towards patients. Hopefully, this allows for greater amounts of structured clinical care to take place and ultimately help the patients engage and respond to treatment.

THE CURRENT STATE OF PLAY OF THE EVIDENCE BASE FOR REFLECTIVE PRACTICE GROUPS

KATHARINE RUSSELL

As a group of practitioners, we are comfortable providers of, and participants in, reflective practice groups. However, we are also aware that RPGs are relatively poorly researched in terms of quantitative data and rigorously controlled studies. In writing this chapter it has been interesting for me to again review the literature and examine the studies and data that are available. It does appear that the increasing focus in policy documents on the importance of RPGs is resulting in the increasing use of RPGs and associated evaluation of the implementation of new RPGs in terms of evaluating different models and looking at different outcomes.

When looking at the literature it is clear that researchers have looked at a range of methods to assess effectiveness; these, however, are predominantly qualitative, eg survey, semi-structured interview and thematic analysis. Whereas most studies in mental health focus on outcomes for patients, in the limited research that has been done, the primary focus of research into RPGs, in terms of change outcome, is staff wellbeing. The benefits for patients are not presumed to be absent but are seen to be affected indirectly; for example, improved staff wellbeing will ensure a more empathic, effective workforce.

From my reading of the literature, it is clear that within reflective practice groups there are a number of different formats. This can vary from closed groups meeting regularly once a week to reflect on ongoing staff–staff and staff–patient dynamics and how different patients can impact on team functioning, to processes that last two to three days set up to reflect on a recent incident or event. A good summary of different models is summarized in a paper by Jones (2014) on models used in social work but that also reflects models used in health settings. This latter model, Critical Reflection (Fook & Gardner, 2007; 2013), was developed to encourage staff to reflect in small group discussions, to challenge assumptions and look at potential changes in thinking and implications for practice. In my experience, the motivation for reflective practice can often increase after some critical incident but the issue with introducing RPG as a response to an incident is that the energy and motivation to maintain this can be lost over time.

The first variation has been described by Warman and Jackson (2007) as an opportunity for staff to share concerns, difficulties and challenges about their work with clients. The purpose is not necessarily

to make changes or find solutions, rather to build a reflective capacity in the participants and the team by looking at the underlying meaning of client behaviour and communication, the ways in which clients can impact on staff at an emotional level and how this impacts on how staff engage and care for clients, the impact of past adverse experiences on the development of future experiences and relationships, and how particular client populations groups can impact on wider staff and organizational culture (Warman & Jackson, 2007).

A different model developed by Ruch (2007a; 2007b; 2009) in child and families work is organised where a participant presents a case and then the group members discuss; initially without posing questions. The groups are asked to stay in 'wondering mode' rather than 'problem solving mode' in order to encourage members to maintain a reflective stance (Jones, 2014). Many of the evaluations of RPGs have been done on pilot groups, presumably to evidence that they will be beneficial in the long-term. For research purposes some of these groups are time-limited and only open to certain staff members whereas in our real-world experience, RPGs are just regular features in a weekly or monthly diary and manage different staff changes and service developments.

Perhaps most well known in psychiatric care is the Balint group. Developed in the 1950s to support GPs in their work, these groups were set up so that participants could present cases with a different kind of focus. These groups were developed to support doctors to consider their patient beyond what they presented in the consulting room and are a closed group that meets regularly with a psychoanalyst leader. The cases that the group were encouraged to present were patients that were hard to engage or that had an emotional impact on the doctor. Once the participant has presented their case, the leader encourages discussion in the rest of the group about the emotional impact of hearing the case on the group and encourages discussion about what may be going on for the patient. Towards the end of the session the presenter will be encouraged to re-engage and discuss what has been helpful or not helpful in listening to the groups process. These groups are now run all over the world. Research on Balint groups has indicated that participation in the group improves the communication skills of the participants (Bascal, 1972) and changes the types of patients the doctors say they have difficulties with (Dokter et al, 1986). Kjeldmand et al (2004), in a comparative study, found those doctors who were in a Balint group reported better control of their work situation, had less frequent thoughts that a particular patient should not attend for a consultation and were less likely to presume that psychosomatic patients were a timeconsuming burden (Rüth, 2009).

We have, of course, noticed the similarities between these models in terms of reflective stances but the differences in practice can also impact on the potential for research in terms of clarity around memberships, frequency, intended outcomes and how they relate to actual outcomes. Groups set up around a particular event that are 'one-off', may have different intended outcomes to those that run regularly and frequently around the day-to-day difficulties of working with particular clients, which capture events as and when they arise, particularly in the long-term. We did not find a study that compared the effectiveness of these different types of formats on outcomes such as staff wellbeing, team cohesion and empathic understanding of clients.

Overall, there are a number of positive outcomes associated with RPGs for staff (Harley, 2017; Heneghen et al, 2014). **Creating a safe space** is a theme that appears in a number of studies (Heneghen et al, 2014). This was one of the findings of O'Neill et al (2019), in a study with liaison psychiatry nurses in an Emergency Department. Similarly, McAvoy (2012) found that creating and maintaining a safe environment was a key task for the facilitator but also that staff actively participate in the RPG in accordance with how psychologically safe they feel in the group.

McVey and Jones (2012) similarly conducted a study looking at themes in feedback from five RPGs in cancer care services and found that feeling safe was an important theme. They described that this was associated with a protected space, nonthreatening/non-judgmental stance and feeling able to admit

imperfections. The issues of staff feeling safe within the group again arose in a staff survey on attitudes conducted by Hartman and Kitson (1995). Staff that found the RPG unhelpful were more likely to note concerns about the safety of the space and the contribution level of other participants.

The facilitator competence and stance are closely linked to creating a safe space. Lees (2017), in an independent evaluation of an RPG project in Brighton and Hove Children's Services, using qualitative data, described RPGs as providing 'time and space to think' as part of several findings but also highlighted that facilitation was key and noted the important functions of maintaining the structure as well as managing group dynamics and 'challenge'.

Improving capacity to manage the emotional impact of work is another theme that I found was frequently highlighted. Powell and Howard (2006) conducted an initial evaluation of RPGs in a group of trainee clinical psychologists and reported participants frequently cited the group as **being helpful in managing the emotional impact of work** but there was less evidence that there was a behaviour change as a result of this insight.

Platzer et al (2000a, 2000b) looked at two cohorts of postgraduate nursing students in their study and focused on processes as well as outcomes. Their outcomes showed that staff felt more confident, more able to empathise with others and were more assertive about offering challenge to poor practice. Furthermore, they reported being able to think more critically about their own practice, found improvements in applying theory to practice and having greater awareness of their professionalism and value base. The processes identified as helpful were receiving validation, encouragement and reassurance from the group, having the opportunities to learn from others' experience and perspectives, being more constructively challenged or criticised and feeling less isolated.

Similarly, Lees (2017), in the study described above, looked at processes for reflection as well as outcomes and found the positive key themes to be: expressing and examining emotional experience, acknowledging and expressing shared experience and resonance, expressing and hearing personal perspectives from others (which could highlight diverging views), wondering and listening and drawing out.

The combination of providing a safe space and improving capacity to manage emotional impact of work underlines the importance of Reflective Practice in supporting staff with achieving the balance of both working in a professionally competent manner at work whilst also allowing the space to be open and honest about the impact of the work on themselves as an individual and a professional, and to process that in a meaningful and helpful way. It allows staff to reflect on the interaction of their professional life and personal experience.

Further studies have also highlighted positive outcomes for staff. Dickey et al (2011) used a mixed-methods study and found that staff of all grades and experience positively rated an RPG. Positive consequences were noted to be **increased personal resilience, increased team cohesion and increased ability to deliver high quality care as a result of attending**. Vachon et al (2010a) found improvements in critical thinking in a study looking at the use of RPG to help occupational therapists utilise research evidence in their practice. An **improvement in team functioning** was also noted in studies by Dawber (2013a, b). Finally, Heneghen et al (2014) found that common positive outcomes in RPGs run by clinical psychologists were **staff wellbeing, service cultures and teamwork**. Common challenges were engagement, group dynamics and a lack of management support – all trials we have faced in our own reflective practice at various times!

Overall, there is moderate qualitative evidence for RPGs with largely positive findings about effectiveness for staff wellbeing but a lack of quantitative data about this. This is clearly an area that

requires further study alongside more rigorous studies looking at the impact and process of RPGs for staff. Where there are continued increases in numbers of RPGs being delivered around the country there would seem to be significant opportunities and need to look at the evaluation of the impact of groups on staff, patients, teams, organizations and the milieu.

Nevertheless, I think it's important to stress that absence of evidence does not mean evidence of absent effect. The summary of studies in terms of process and outcome clearly highlights the value staff place on RPGs. Increasing ability to manage emotions, solve problems, increased reflectionin-action and improved team cohesion are recurrent themes. There were also similarities in the challenges identified, ie conflict between work demands and being freed up to attend RPG, the role of the facilitator and their ability to create a 'safe space'. Few studies were able to evidence changes in ward atmosphere or patient outcomes. However, there is an acknowledgment that this is harder to measure in a controlled way given the many variables that can affect patient outcomes. We all feel that more comprehensive and longitudinal research is required – and this has become an increasing priority in our work settings.

KEY PRINCIPLES OF MULTIDISCIPLINARY TEAM REFLECTIVE PRACTICE GROUPS

ADAM POLNAY

In view of the dynamics described in Jon's introduction, analysis of patients' relationships with clinicians as caring figures and clinicians' responses, both helpful and unhelpful, needs to be a primary focus of treatment. This work is a central aim of multidisciplinary team RPGs. To create a safe and well-functioning clinical team, it is vital that staff are:

- *aware* of emotional responses to the work;
- recognise that these *are normal*;
- and make time to *reflect on and process* these responses in appropriate settings (Johnston and Paley, 2013; Thorndycraft and McCabe, 2008).

These are all factors that have been remarked on by Katharine in her section, above, about the evidence base. Led by appropriately skilled facilitators, multidisciplinary team RPGs can provide a regular, safe, confidential, nonjudgmental and supportive setting for the whole clinical team to reflect together on their interactions with patients and understand some of the dynamics that they are part of.

PRACTICAL PRINCIPLES FOR REFLECTIVE PRACTICE GROUPS

Prior to going ahead and setting up an RPG, we have found that initial teaching about interpersonal dynamics is helpful to generate interest in this area and to increase clinicians' sense that making time to stop and reflect is a priority. These teaching sessions may then facilitate the clinical team, in due course, to request a more regular reflective practice group.

To create a secure frame for the group, the group facilitator works with team leaders to establish a regular time and a confidential space for the team to meet. In the initial RPG sessions and when new members join, the primary task of the group is explained. Namely, to provide a regular, non-judgmental setting to explore clinical encounters with patients, team dynamics and organizational issues (Patrick et al, 2018). To help with this task, a supportive and empathic stance is taken by group members, led and modelled by ourselves as the facilitator. Clinical situations and encounters with

patients are explored, with a constructively challenging and noncollusive stance from the facilitator where needed.

There is a confidentiality boundary, with appropriate limits to this, for the sessions, which helps participants to express their countertransference feelings so these can be thought about and processed. The edges of the boundary we usually hold are around issues to do with risk of harm to group participants, patients or others in their system. Everyone is invited to participate in discussion. Varying perspectives are encouraged as people will 'hold' different parts of an overall clinical situation.

We are all very clear that RPGs aren't therapy for staff. The facilitator keeps the focus on work situations and staff members' responses to these, as opposed to the personal exploration found in therapy. The facilitator will step in when needed to keep members feeling safe and also to ensure that no one individual is 'in the spotlight'.

Participants keep responsibility for their work (Hawkins & Shohet, 2007). The RPG is separate and distinct from other formal patient management meetings, such as ward rounds. In our experience, this allows staff to explore their responses to patients more easily and with less pressure to try and 'solve' problems too soon, which can foreclose the discussion.

OUR VIEW OF THE ROLE AND STANCE OF FACILITATOR

RPG facilitators are not part of the teams that they are helping to reflect. This 'outsider' status preserves facilitators' ability to hold a democratic, neutral stance in relation to the teams they work with. Furthermore, it will prevent them becoming part of the problems they are trying to assist with. It is important that the same RPG facilitator runs the sessions for a particular group, to allow a trusting relationship to develop and to provide consistency (Patrick et al, 2018).

The role and stance of the facilitator draws on relational therapy approaches, Balint group practice, group-work leadership skills, systemic approaches, and skills as an educator (Johnson et al, 2004; Johnston & Paley, 2013; Scanlon, 2012). Our main role is to facilitate and conduct the discussion and exploration by the group, as opposed to being overly didactic. This allows the clinical team to work things out at their own pace and provides time needed to name, reflect on and process feelings. An RPG is not primarily about gaining factual knowledge from an 'expert' facilitator about what is happening. Rather than coming in and giving a verdict on what is being said, the facilitator aims to tolerate and keep in play contradictory and multiple views as expressed by group members (Johnson et al, 2004). This helps generate and preserve a plurality of ideas, which is important as no one person can pick up on all aspects of the patient. This stance can also help teams to reflect on 'splitting' (Gabbard, 2010) within the team.

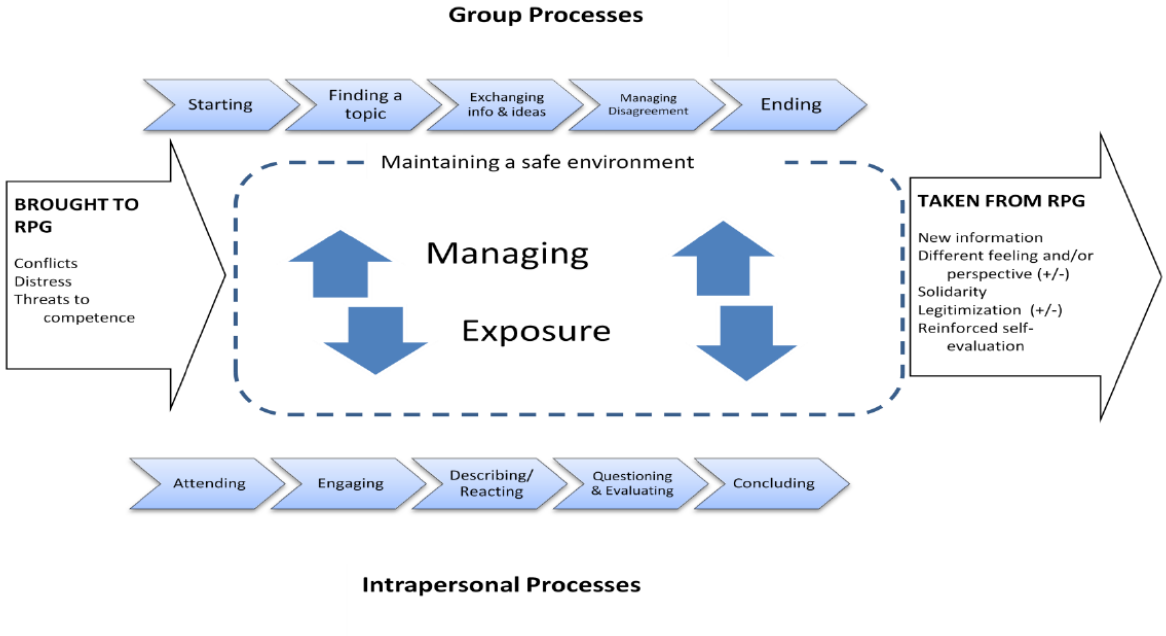
Drawing on psychodynamic and group leadership skills, I aim, as the facilitator, to keep the group thinking and exploring about what is being discussed, including looking for meaning and asking for feelings in relation to the clinical work. Without being overly didactic, the facilitator attends to keeping the group on task. In any group when difficult situations are being discussed there may emerge a 'flight from the group' phenomena whereby the group starts to discuss or criticise people who are outside the RPG. The role of the facilitator here is to steer the group back to task, perhaps using humour, observation, or empathy (eg noticing how hard it may be to talk about the work with the patient).

We have outlined elsewhere a suggested competency framework for RPG facilitators, which can be used to inform appropriate training for facilitators (Patrick et al, 2018).

Overview of a typical RPG session

Combining observation of RPGs with qualitative accounts from participants, McAvoy (2012) developed a model that conveys the course of a typical RPG:

Figure 1 - Theoretical model of processes within RPG



A reflective practice session usually starts with members introducing themselves as needed, and (restating) the key principles of the group for the benefit of new members and as a reminder for existing members. As the facilitator, we have all recognised that a key role at the start of the session (and potentially throughout) is setting and maintaining group frame and norms.

There then typically follows a phase where the group finds a topic. One or more group members then talk about a clinical situation, which may include conflicted feelings, perceived threats to competence, or complicated clinical situations. With the topic decided and some 'material' brought to the group there follows a phase of exchanging ideas as different group members respond to what they have heard or describe their own direct experience of the clinical situation. Understanding deepens as the group 'tries to digest' aspects of the clinical encounter 'that could not be seen before' (Rüth, 2009). There sometimes emerge differences in opinion or disagreements, and here our role is to help the group to make use of these divisions in the service of understanding the interpersonal situation better. From an individual participant's perspective, the various views and discussion put forward by the group often result in the participant re-evaluating their initial responses.

Processes underlying reflective practice groups

Containment of emotions and experiences

Containment refers to a fundamental process of finding understanding and managing our feelings through certain interactions with others (Gabbard, 2010). The process starts with us communicating with trusted others about our distressing or confusing feelings and experiences. All being well, the other person (or a group) notices what is being communicated, reflects on the impact on them, and then can hand something back (Bion, 1962) to us about our distress in a modified and acceptable form.

This interaction leads us to feel more 'contained' about our original experience, ie we have a sense of being understood and that our experience is more bearable than we first felt. It is well recognised that a considerable element of patients improving in psychiatric hospitals is due to their distress and disturbance being 'contained' by interactions with steady, calm and receptive staff (Adshead, 1998).

RPGs can increase clinicians' capacity to act as a container for patients' experiences. The safe and supportive setting is conducive to staff noticing and exploring what is happening in the patient's mind and how the clinician feels in the patient's presence. The RPGs can then help clinicians to make sense of their feelings in relation to the patient, ie to explore what it is about the patient's sense of himself or others that ends up evoking certain feelings in others. Finding understanding and support in RPGs (Adlam, 2016) may increase clinicians' capacity to tolerate their experience, so that it may be more possible to sustain working with disturbing patients, without, for example, becoming as short-tempered or overwhelmed with a sense of hopelessness.

Clarifying clinicians' responses to patients

Even for the most experienced and skilled clinicians, our own perception of and responses to patients, may not always be clear to us (Rüth, 2009). Bringing a clinical encounter for discussion with other clinicians in the RPG allows for multiple perspectives to emerge, and for other group members to 'pick up' aspects of the patient-clinician interaction that the clinician was initially unaware of (but may have been affected by). One example could be in an RPG, a clinician realised he had been acting somewhat harshly towards a patient due to feelings of dislike towards the patient that he previously had only been dimly aware of.

Exploring responses in the wider system to working with patients

If staff members' feelings in relation to patients are not adequately named and processed, as well as having the risk of counterproductive responses to the patient, these feelings may, without realising it, be displaced onto other parts of the organization (Moore, 2012). It is also recognised (Moylan, 1994) that an institution can pick up difficulties and defenses of their particular client group. An institution or system can struggle to contain the distress and disturbance from working with many patients who may have similar kinds of difficulties. For example, a general ethos within staff in a forensic institution may be somewhat suspicious, or the staff ethos within an anorexia nervosa service may be to over-work and not take proper lunch-breaks. In RPGs, through observing and discussing these systemic responses, 'staff are more likely to be aware of when [these are] happening and to use feelings to tackle the problem in a direct and appropriate way' (Moylan, 1994).

Managing the level of emotional contact with patients

For clinicians who are overly emotionally disturbed by clinical work, RPGs can help provide perspective and objectivity; and for clinicians who have become more detached and inured to clinical work, the groups encourage closer awareness of the emotional aspects (Evans, 2016). We, as facilitators, have recognised a need to adapt according to the level of emotional contact of the clinician – taking a more exploratory stance that is attentive to the emotional aspects of the clinical work to help bring someone closer; and a more supportive or intellectual stance for someone overly emotionally connected to allow permission to step back and leave work at the door.

Working with the parallel process within the group itself

When discussing a disturbing or difficult staff-patient encounter in a group, sometimes a 'parallel process' can emerge in the group itself (Scanlon, 2012). Namely, one person (or more) becomes more identified with the patient's position and another (or others) with the staff member's position. A version of the situation that is being discussed by the group actually gets replayed within the group itself. If carefully managed, this may provide an opportunity for greater understanding of the situation under discussion as it becomes a real 'live' situation rather than something more abstract.

It is the facilitator's role to manage this situation, according the particular circumstances and level of sophistication and development of the group. With a reasonably secure and experienced RPG, it may be possible for the facilitator to sensitively draw attention to the parallel process, normalise this, and attempt to use it as a vehicle for understanding. In other situations, the facilitator may need to fairly quickly reduce the level of affect in the group, use supportive explanations, and perhaps steer the group onto less emotionally charged ways of exploring the topic in hand.

JOURNEY'S END?

We hope that this tour through one type of reflective setting has given you a sense of the 'whys', 'hows' and 'whats' of our perspective. We acknowledge that 'there is more than one way to skin a cat' and, at the risk of becoming overly metaphorical(!), we have all tried to keep people in the reflective tent rather than treating RPGs as some mysterious and exclusive club. You will hopefully have seen that there is still work to be done in demonstrating more concretely what we feel convinced about anecdotally, that RPGs are a way to help us, the patients and our organizations engage in the work of caring more effectively and safely.

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